## Identifying psychiatric rehabilitation interventions: an evidence and value based practice

## **MARIANNE FARKAS**

Center for Psychiatric Rehabilitation, Sargent College of Rehabilitation Sciences, Boston University, 940 Commonwealth Ave. West, Boston, MA 02214, USA

Psychiatric rehabilitation is a field that is over thirty years old, rooted in the principles of physical rehabilitation, with its own knowledge base, philosophy and interventions (1-3). Rössler's article does an excellent job in reviewing the basic concepts and characteristics of psychiatric rehabilitation and some of the evidence based interventions or program models that have, rightly or wrongly, come to be associated with it.

Value based medicine has emerged as a twin concept to evidence based medicine and acknowledges the importance of the patient's perception of the relevance of an intervention (4). Value based practice for individuals with serious mental illnesses starts with the notion that recovery, or the taking back/

regaining of a meaningful life (1,5), has become not only scientifically possible (6), but also is perceived as the relevant mission for services (6-8). The overall purpose of a psychiatric rehabilitation service, as compared to other types of services, is to contribute to this outcome by enhancing functioning in a role valued by society and selected by the individual (1). The fundamental values of psychiatric rehabilitation, as integral an element of the field of rehabilitation as its evidence base, include the critical importance of empowerment and choice, partnership, hope, a focus on an individual's strengths and interests as well as limitations, and an outcome or results orientation, among several others (3,9).

Whether or not a particular intervention is considered to be a rehabilitation intervention, therefore, is not defined by the simple fact that it focuses on skills or supports for individuals with serious mental illnesses. It is defined rather by its contribution to the primary outcome of enhanced functioning in a valued role and the congruence of the value base of the intervention itself. Is the person more able to be successful and satisfied as a mother, tenant, landlord, lawyer, janitor or student as a result of the intervention offered? Or is the intervention effective only at improving grooming skills? Is grooming the critical skill to become a student? Is skills training used to manage symptoms? It has long been clear that there is only a weak correlation between symptoms and role functioning (1,10,11): improving symptom management, while critically important to treatment outcomes, is not, therefore, a rehabilitation intervention. Those case management interventions that are effective in preventing rehospitalization and maintaining stability, but not in achieving a valued role, are also not rehabilitation interventions.

Equally, practices that include effective interventions not congruent with the value base of rehabilitation are not, strictly speaking, psychiatric rehabilitation. Interventions that are imposed on individuals, as Rössler points out, are not consistent with rehabilitation. Individuals cannot be subtly coerced into participating in rehabilitation. Engaging individuals depends upon their current state of readiness to begin thinking about a valued role (9). Readiness can be developed, if the individuals are interested but not ready (6,7). Interventions not focused on an individual's choice of role are not consistent with rehabilitation. Interventions that don't assess and build upon the person's strengths and interests are not consistent with rehabilitation. Choice, partnership and hope can be facilitated through processes such as values clarification, problem solving processes and a myriad of other techniques designed to help an individual use his/her strengths and interests to choose, get and keep his/her valued role.

This process can be used in any effective program model (e.g., supported employment) (13) and has been demonstrated to be successful even for the most disabled individuals (1,14,15).

In order to maximize the multidi-

mensional process of recovery, access to a wide array of services is recommended, if services are used at all (8,16). This requires that psychiatrists be clear about the expected contributions and outcomes of each, to avoid confusion and unmet expectations due to inaccurate labeling of services. Psychiatric rehabilitation services should be those which are effective in facilitating success and satisfaction in valued roles through a process clearly congruent with accepted rehabilitation values.

## References

- Anthony WA, Cohen MR, Farkas M et al. Psychiatric rehabilitation, 2nd ed. Boston: Center for Psychiatric Rehabilitation, 2002.
- Anthony WA, Cohen MR, Farkas M. Psychiatric rehabilitation. Boston: Center for Psychiatric Rehabilitation, 1990.
- Farkas M, Anthony WA. Psychiatric rehabilitation: putting theory into practice. Baltimore: Johns Hopkins University Press, 1980
- Brown M, Brown G, Sharma S. Evidence based to value based medicine. Chicago: American Medical Association Press, 2005.
- 5. Deegan P. Recovery: the lived experience. Psychiatr Rehab J 1988;11:11-9.
- Harding CM, Zahniser JH. Empirical correction of seven myths about schizophrenia with implications for treatment. Acta Psychiatr Scand 1994;90(Suppl. 384): 140-6.
- 7. Anthony WA, Rogers ER, Farkas M. Research on evidence based practices: future

- directions in an era of recovery. Commun Ment Health J 2003;39:101-14.
- The President's New Freedom Commission on Mental Health. Achieving the promise: transforming mental health care in America, final report. www.mentalhealthcommission.gov/reports/FinalReport/toc.
- Farkas M, Sullivan Soydan A, Gagne C. Introduction to rehabilitation readiness. Boston: Center for Psychiatric Rehabilitation, 2000.
- Strauss JS, Carpenter W. The prediction of outcome in schizophrenia: II. Relationships between predictor and outcome variables. Arch Gen Psychiatry 1974;31:37-42.
- Drake R, McHugo G, Bebout R et al. A randomized clinical trial of supported employment for inner city patients with severe mental disorders. Arch Gen Psychiatry 1999;56:627-33.
- Cohen M, Forbess R, Farkas M. Psychiatric rehabilitation training technology: developing readiness for rehabilitation. Boston: Center for Psychiatric Rehabilitation, 2000.
- Drake RE, McHugo GJ, Becker DR et al.
   The New Hampshire study of supported employment for people with severe mental illness. J Consult Clin Psychol 1996;64: 391-9.
- 14. Farkas M. Readaptation psychiatrique: une approche et un processus. Sante Mentale 2006;106:51-8.
- Shern DL, Tsembaris S, Anthony WA et al. Serving street dwelling individuals with psychiatric disabilities: outcomes of a psychiatric rehabilitation clinical trial. Am J Publ Health 2000;90:1873-8.
- Farkas M, Gagne C, Anthony WA et al. Implementing recovery oriented evidence based programs: identifying the critical dimensions. Commun Ment Health J 2005; 41:141-58.